B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

To contain growth in the rate paid for outpatient services.

To encourage outpatient resources be used when they are appropriate substitute for inpatient hospital services.

To discourage the inappropriateness of outpatient hospital resources as a substitute for physician office and clinic services.

To ensure the continued existence and stability of the core providers who serve the Medicaid population.

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EFFECTIVE DATE: 01/01/04
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SUPERCEDES: N/A

IV. Payments to Out-of-State Providers:

Payments to out-of-state providers shall be made based on the lesser of the fixed fee specified for the service or the charge for the service in the case of surgery, nonsurgery or treatment, therapy and testing services.

2b. Rural Health Clinics:

Effective January 1, 2001, in accordance with the requirements of BIPA 2000, an alternative payment methodology will be used for reimbursement of Rural Health Clinics (RHCs). The alternative payment methodology is described below. It has been determined by a comparison of rates using the prospective payment methodology (PPS) and the alternative payment methodology that the alternative methodology as described will provide reimbursement to RHCs which is at least equal to the amount that would be received using the PPS methodology. The FY 01 PPS baseline rates were determined by weighing the RHC specific rates for FYs 1999 and 2000 using Medicare cost principles, by the number of Medicaid encounters provided each year.

The alternative payment methodology is a cost based retrospective reimbursement system. Reimbursement for medically necessary services will be made at 100% of the all-inclusive rate per encounter as established by the Medicare Intermediary. Actual cost information shall be obtained from the Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period. Provider-based RHCs with less than fifty (50) beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

At year-end settlement under the alternative payment methodology, comparisons will be made to assure that the final rate paid based on the RHC's fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

Effective January 1, 2004, there is a standard co-payment amount of $2.00 per encounter provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53).

Circumstances requiring special consideration/disposition are discussed below:

1. For RHCs not agreeing to the cost based alternative payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for: 1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.

2. Under the alternative payment methodology, new RHCs will initially be reimbursed at 100% of the all-inclusive encounter rate as determined by the Medicare Regional Intermediary. Reimbursement is subject to annual revision to the actual cost rate as determined by the Medicare Intermediary based on the RHC's fiscal year. In the event that a new RHC wishes to elect the PPS rate, the PPS rate established shall be equal to 100% of the reasonable costs used in calculating the rates of like RHCs in the same or an adjacent area with a similar caseload.

3. For those RHCs participating as a member of a Medicaid managed care entity (MCE), and receiving either cost based or PPS reimbursement, quarterly reconciliation will be completed. Where necessary, supplemental payments will be made to ensure that the RHC does not receive less reimbursement than would be received under the cost based or PPS reimbursement methodologies. A final annual reconciliation of quarterly supplemental payments will be included in the RHC's fiscal year cost settlement and rate determination.

2c. Federally Qualified Health Centers:

Effective January 1, 2001, in accordance with BIPA 2000, an alternative payment methodology will be used for reimbursement of Federally Qualified Health Centers (FQHCs). The alternative payment methodology is described below. It has been determined by a comparison of rates using the prospective payment methodology (PPS) and the current alternative payment methodology that the alternative methodology as described will provide reimbursement to FQHCs which is at least equal to the amount that would be received using the PPS methodology. The FY 01 baseline rates were determined by weighing the FQHC provider specific rates for provider FYs 1999 and 2000 based on reasonable cost principles, by the number of Medicaid encounters provided in each year.

The alternative payment methodology is a cost based retrospective reimbursement system. The SCDHHS uses a modified Medicare RHC actual cost report as the cost report format for FQHCs. The reports, as submitted, shall be reviewed for accuracy, reasonableness and the allowability of costs as defined by Medicare reasonable cost principles. Reimbursement will be made at 100% of Medicare reasonable costs with the following constraints: (1) The minimum productivity level for physicians shall be 4,200 patient visits per year; for mid-level practitioners, 2,100 patient visits per year; and for OB/GYN physicians, 3,360 patient visits per year; (2) Overhead costs shall be limited to not more than thirty percent (30%); and, (3) Out-of-state FQHCs shall be paid the statewide encounter rate as determined from the most recently completed state fiscal year. To ensure that reimbursement will be made at 100% of Medicare reasonable costs, subject to the above mentioned constraints, adjustment to cost shall be made on a retrospective basis based upon review of the FQHCs' fiscal year end cost report. Furthermore, the reported cost information shall be used for establishing or modifying the rates of payment for future services rendered by the FQHC.

For those facilities that are not PHS grantees but are designated as ''look alikes'', the same cost principles and constraints shall apply as mentioned above for FQHCs.

At year-end settlement, under the alternative payment methodology, comparisons will be made to assure that the final rate paid for a FQHCs' fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

Effective January 1, 2004, there is a standard co-payment amount of $2.00 per encounter provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53).

Circumstances requiring special consideration/disposition are outlined below:

1. For FQHCs not agreeing to the cost based alternative payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for: 1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.

2. Under the alternative payment methodology, new FQHCs will initially be reimbursed at 100% of the all-inclusive encounter rate as determined from a review of a budget submitted by the FQHC. Reimbursement will be reconciled to actual cost on an annual basis based on the FQHC's fiscal year. In the event that a new FQHC wishes to elect the PPS rate, the PPS rate established shall be equal to 100% of the reasonable costs used in calculating the rates of like FQHCs in the same or an adjacent area with a similar caseload.

3. For those FQHCs participating as a member of a Medicaid managed care entity (MCE), and receiving either cost based or PPS reimbursement, quarterly reconciliation will be completed. Where necessary, supplemental payments will be made to ensure that the FQHC does not receive less reimbursement than would be received under the cost based or PPS reimbursement methodologies. An annual reconciliation of quarterly supplemental payments will be included in the FQHC's fiscal year cost settlement and rate determination.

2e. Indian Health Service (IHS) Facilities:

Effective July 1, 1999, DHHS will reimburse IHS facilities (638 facilities) at the rate as determined by the Indian Health Service. For Calendar year 1999, the rate is published in the Federal Register/Vol.64, No. 16/Tuesday, January 26, 1999/Notices, page 3955. Subsequent year rates shall be announced in the Federal Register. The rate shall be an all-inclusive encounter rate per visit for the provision of medically necessary out-patient services provided to both Native and non-Native Americans.

Coinsurance and Deductibles will be paid by the Medicaid Program (Title XIX) program where the individual has joint eligibility for Medicare and Medicaid.

Physician Therapy. Occupational Therapy and Psychological Services:

These services include physical therapy services, occupational therapy services and psychological testing, evaluation and counseling services and are reimbursed at an established fee schedule based on cost or by the methodologies set forth in other sections of the Plan.

Nursing Services for Children Under 21:

Initial reimbursement to providers of nursing services for children under the age of 21 is made on the basis of an established fee schedule not to exceed the prevailing charges in the locality for comparable services under comparable circumstances. Reimbursement will be provided on a unit of a quarter of an hour basis for skilled nursing services and a per encounter basis for medication administration and other similar procedures. The current reimbursement rates are based on rates or fees reimbursed for similar services.

State and local government providers must submit annual actual cost and service delivery data. The State shall utilize Medicare reasonable cost principles as well as OMB Circular A-87 and other OMB circulars as may be appropriate during its review of actual allowable costs. Future reimbursement rates to state and local government providers shall be the lesser of actual allowable documented cost or the established fee.

4.c Family Planning Services and Supplies:

Family Planning Services are reimbursed at an established fee schedule based on cost or by the methodologies set forth in other sections of the Plan.

5. Physician Services:

[Effective January 1, 2004, there is a standard co-payment of $2.00 per office visit when co-payment is applicable. Reimbursement for physicians services will be the amount calculated by using a State agency determined percentage of the Medicare Resource Based Relative Value System (RBRVS) Fee Schedule, or the amount calculated by using a payment schedule based upon the relative value of each procedure code multiplied by a conversion factor assigned by the State Agency, or lesser of actual charge. Relative values are based on those established for the Medicare RBRVS. For those procedures not having a relative value, reimbursement is based on data collected within the Medicaid Management Information System or by a review conducted by medical personnel to establish the relative value. The percentage and/or the conversion factor will be reviewed annually prior to the close of each State fiscal year. Updates to the payment schedule may be targeted to specific procedure codes or ranges of procedure codes. Some of the considerations for targeting updates are: ensuring provider participation, eliminating inequities with the system, ensuring providers recover out-of-pocket expenses, etc. The payment schedule is applied uniformly to all reimbursement without consideration to locality or specialty of the physician. Nurse practitioners will continue to receive reimbursement at 80 percent of the physician's rate.]

Effective January 1, 2001, pediatric sub-specialist providers will receive an enhanced Medicaid rate for evaluation & management and medical &

Reimbursement for laboratory (pathology) services performed by individual practitioners is calculated as specified in 5.

End State Renal Disease - Reimbursement for ESRD treatments, either home or in center, will be an all inclusive fee based on the statewide average of the composite rates established by Medicare. The reimbursement will be an all inclusive fee to include the purchase or rental, installation and maintenance of all equipment.

6.a Podiatrists' Services:

Effective January 1, 2004, there is a standard co-payment of $1.00 per office visit when co-payment is applicable. Reimbursement is calculated in the same manner as for Physicians' services. Refer to 5.

6.b Optometrists' Services (Vision Care Services):

Effective January 1, 2004, there is a standard co-payment of $1.00 per office visit when co-payment is applicable. Payment will be according to an established fee schedule for all services not provided through the sole source contract. Effective February 1, 1982.

6.c Chiropractor's Services:

Effective January 1, 2004, there is a standard co-payment of $1.00 per office visit when co-payment is applicable. Reimbursement is calculated in the same manner as for Physicians' services. Refer to 5.

6.d Certified Registered Nurse Anesthetist: Reimbursement is calculated at one-half the rate of the Anesthesiologist, Physician Services. Refer to 5.

Nurse Practitioner: Effective January 1, 2004, there is a standard co-payment of $2.00 per office visit when co-payment is applicable. Reimbursement is calculated at 80 percent of the rate for Physician Services. Refer to 5.

Psychologists: Psychological services are reimbursed at an established statewide fee schedule as based on the Methodology outlined in the Physician Section 5, Attachment 4.19-B, Page 2a. All requirements identified under CFR 447.200ff and 447.300ff shall be met.

Licensed Midwives' Services: Effective January 1, 2004, there is a standard co-payment of $2.00 per office visit when co-payment is applicable. Reimbursement is calculated at 65% of the rate for physician services. Refer to 5a and 5b.

7. Home Health Services:

A. Nursing Services, Home Health Aide Services, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology are provided and reimbursed based on the lesser of allowable Medicare costs, charges, or the Medicare cost limits. At the end of each Home Health Agency's fiscal year end, an actual cost report must be submitted which is used for the purpose of completing a cost settlement based on the lesser of allowable Medicare costs, charges, or the Medicare cost limits.

Effective for cost reporting periods beginning on or after October 1, 2000, the Medicare per-visit limits used in Home Health rate determinations will be those published in the August 5, 1999 Federal Register for cost reporting periods beginning on or after October 1, 1999. Medical supplies, which are used in the provision of routine home health services, are initially reimbursed on charges; however, during the fiscal year end cost settlement, an adjustment is made reflective of the cost to charges ratio for medical supplies. Durable medical equipment purchased through a home health agency will be reimbursed in accordance with Section 12 c of this plan 4.19-B. Effective January 1, 2004, there is a standard co-payment amount of $2.00 per visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Supplies are exempt from co-payment requirements.

Effective October 1, 2000, Home Health Agencies entering the Medicaid program for the first time will be reimbursed at the lesser of Medicare cost limits based on the per-visit limits as published in the August 5, 1999 Federal Register, charges, or an interim rate established by the Medicaid State Agency until the submission of actual costs.

B. Durable Medical Equipment is equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose. Generally it is not useful to a person in the absence of illness or injury and is appropriate for use in the Reimbursement is based on the lesser of billed charges, State Agency determined allowable fees, or the Medicare prevailing charge (50% percentile).

Effective January 1, 2004, there is a standard co-payment (42 CFR 447.55) of $3.00 for Durable Medical Equipment services furnished when co-payment is applicable (42 CFR 447.53). Pregnant women, individuals participating in family planning services, infants and children up to ate 19 will not be subject to co-pay.

Clinical Services:

Payment will be made according to an established fee schedule and will not exceed the allowable payment established for those services by Medicare (Title XVIII). There is a standard co-payment of $2.00 per claim for clinic services (42 CFR 447.55) provided by County Health Departments when co-payments is applicable (42 CFR 447.53). Pregnant women, individuals participating in family planning services, infants and children up to age 19 will not be subject to co-pay.

10. Dental Services:

Reimbursement to providers of dental services is made on the basis of an established fee schedule not to exceed prevailing charges in the state. Reimbursement will be provided on a per procedure basis. This percentile was determined by an independent company's analysis of all dental claims filed in the state within the calendar year. The current reimbursement will not exceed the 75th percentile of usual and customary reimbursement.

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Effective January 1, 2004, there is a standard co-payment (42 CFR 447.55) of $3.00 for dental services furnished when co-payment is applicable (42 CFR 447.53). Pregnant women, individuals participating in family planning services, infants and children up to age 19 will not be subject to co-pay.

11.a. Physical Therapy/Occupational Therapy:

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11.b. Payment will be according to an established fee schedule as based on the methodology outlined in the Physician Section 5, Attachment 419-B, Page 2a. All requirements identified under 42 CFR 447.200ff and 447.300ff shall be met.

11.c. Speech/Language and Audiological Services:

Payment will be according to an established fee schedule.

12.a. Prescribed Drugs:

Medicaid pays for FDA approved prescribed drugs with stated exceptions described in Attachment 3.1-A, Item 12-A, Limitation Supplement.

1. Basis for Payment:

A. MULTIPLE SOURCE DRUGS

Reimbursement for covered multiple-source drugs in the Medicaid program shall be limited to the lowest of:

(1) The Federally-mandated upper limit of payment or South Carolina Maximum Allowable Costs (SCMAC), for the drug less the current discount rate (10%), plus the current dispensing fee; or

(2) The South Carolina Estimated Acquisition Cost (SCEAC) which is the average wholesale price (AWP) less the current discount rate (10%), plus the current dispensing fee; or

(3) The provider's usual and customary charge to the public for the prescription as written for the brand actually dispensed.

B. OTHER DRUGS

Reimbursement for covered drugs other than the multiple-source drugs with CMS upper limits shall not exceed the lower of:

(1) The South Carolina Estimated Acquisition Cost (SCEAC), which is the average wholesale price (AWP), less the current discount rate (10%), plus the current dispensing fee; or

(2) The provider's usual and customary charge to the public for the prescription as written for the brand actually dispensed.

''Free-Standing contracting pharmacies not otherwise reimbursed by Medicaid for others service on a cost basis.

''In-House'' pharmacies reimbursed by Medicaid on a cost basis for other services.

Dispensing physicians are reimbursed only for the cost of the drug.

Additional Upper Limit Application:

The upper limits are described in this Attachment Section also apply in cases where prescribed drugs are furnished as part of SNF or ICF services or under prepaid capitation arrangements. Contracts between the State Agency and the underwriter, carrier, foundation, HMO or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement or prescribing drugs.

12.c Prosthetic Devices and Medical Supplies, Equipment and Services:

Certain medical services, supplies, and equipment (including equipment servicing) that do not generally vary significantly in quantity will be reimbursed at a rate not to exceed the rate established by the Medicare carrier in the area at the lowest charge level at which the service, supplies, and equipment are widely and consistently available within their locality according to the procedures prescribed in 42 CFR 405.511. A list of these items of service is published in the federal regulations. This upper limit is applicable to such services furnished under both Medicare and Medicaid.

For selected services and items furnished only under Medicaid (and identified and published by the Secretary of HHS by regulations), the Medicaid agency must calculate the lowest charge levels under the procedures specified in 42 CFR 405.511© and (d), and limit payments to that amount.

[Effective January 1, 2004 there is a standard co-payment (42 CFR 447.55) of $3.00 for Durable Medical Equipment services furnished when co-payment is applicable (42 CFR 447.53). Pregnant women, individuals participating in family planning services, infants and children up to ate 19 will not be subject to co-pay.]

Hearing Aids - A consolidated contract between the Department of Health and Human Services (DHHS) and Department of Health and Environmental Control (DHEC) is in effect to provide hearing aids, accessories and repair to eligible Medicaid recipients 21 years old and under using S-codes.

Home Dialysis - Reimbursement for equipment and supplies are included in the all inclusive rate paid only to the End Stage Renal Dialysis Clinic.

12.d Eyeglasses

Services are provided under a sole source contract. Reimbursement is based on competitive bid. The duration of the contract is one year.